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J. D. DUNSHEE, M.D., Director

Weekly Bulletin

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Public Health

By H. W. Hill, M.B., M.D., D.P.H., LL.D., L.M.C.C., University of British Columbia, Vancouver, B. C.

What basic units are common to medicine and to public health? Obviously the same two units that are common to all sciences dealing with humanity—first, the individual, and then, his surroundings.

Medicine, very naturally but near-sightedly, has always until very lately concentrated its attention chiefly on the individual—and almost always on the sick individual.

Public health, with equal near-sightedness, has always until very lately concentrated its attention chiefly on the surroundings—and almost always on the nonliving surroundings; but in recent years both public health and medicine have had cause to shift their respective viewpoints, somewhat conversely; but with great gain to both in their respective campaigns against disease and death. These converse shifts were due to the long-delayed recognition of the fact that neither medicine nor public health, huge though the field of each is, and distinct in much of their detail as both are, can achieve full success in reaching their mutual objective—reducing human ills and misery—unless the relationships of each field to the other be mutually correlated.

Studies of individuals can never be too intensive, or too complete. Studies of their surroundings—ditto. But it is the studies of the relations and reactions of individuals to their surroundings—and vice versa—which yield the most immediate and the most important advances.

In public health circles, the specific result of the shift was an acute realization that, of all the surroundings of man, the portion constituted by living things, theretofore almost ignored, was in truth far more intimately significant than all the rest, theretofore all but exclusively considered. Public Health had long, and largely ineffectively, concerned itself with physical, mechanical surroundings—drains, sewers, water supply, ventilation, housing—as of themselves the controlling factors in health and disease. But at last it was soon that the physical and mechanical surroundings produced disease in the individual chiefly by indirection—chiefly as they might aid or hinder the impinging on him of the far more direct, dynamic and intimate activities of his biological surroundings; the bacterium, the flea, the fly, the mosquito, the rat, the human "carrier." And even so, of at least equal importance was the reaction of the individual to the living thing thus brought into direct relation with him. For instance, a water supply might be abundant or scanty, clear or cloudy, tasteless or unsavory, hard or soft; but in the production of typhoid fever, these physical features were negligible. Good, bad or indifferent in itself, the water supply produced typhoid fever if when and as the water supply affected the biological surroundings of its human consumers—only if it introduced into the intestines of its consumers the *Baccilus typhosus;* moreover, even then, only if the individual's reaction to the germ favored its development. Hence the great shift in public health from mechanics to biology; from surroundings only to the intimate interrelations of the surroundings with the individual.

It, was of course, the discoveries relating to pathogenic microorganisms that originated and directed this shift in public health attention from surroundings alone to the surroundings and the individual. It was these same discoveries that also originated and directed the converse shift in medicine's attention from the individual alone to the individual and his surroundings. In surgery very markedly did this shift occur. In ward and operating room, the surroundings of the patient, almost ignored before, now received the most meticulous attention—and specifically to exclude his biological enemies. In internal medicine also, tuberculous sputum, typhoid feces, etc., were now regarded seriously and dealt with specifically to destroy their biological contents.

But the wider and more detailed attention of medicine to all surroundings is of more recent growth. As one of the results of medical cooperation in workmen's compensation and war pensions, the patient's surroundings, physical, biological, psychological, sociological, have received growing consideration in medical thought. To determine, for instance, the one medical point of the percentage disability of a particular patient, the attention of medicine is perforce directed on that particular patient's particular surroundings, in all their interrelations with him, and his with them.

The earlier medicine considered chiefly the symptoms of the individual; then, later, the pathological anatomy underlying those symptoms. Later still came pathological physiology, and now, in due sequence, the consideration of the patient's whole pathological life—first in relation to his own immediate surroundings, but also to his community, to his country, to all humanity.

All modern medical literature teems with admonitions to "treat the patient, not merely the disease." That is, to take into consideration the surroundings of the patient, of every kind. Again, the admiration for and yearning to revive the status of the old-time family physician, so often now repeated in medical circles, usually is based on the expressed belief that he knew not alone his patients but their multifarious surroundings also.

No better local illustration of this widening viewpoint of our most modern medicine can be offered than that of the establishment here in British Columbia of a committee of medical men organized to study cancer—and organized to study it from all possible angles, not merely to study its pathology or treatment. Thus have the fields of medicine and public health, originally so distinct as to be considered at times almost opposed, gradually grown until it is now obvious that they are but the two sides of the same shield—the shield borne by humanity against disease and death.

Observers coming from opposite directions to this shield may see respectively, at first, only one single side. Closer inspection shows that the two distinctive sides are after all intimately and firmly interlocked; and that it is this very interlocking that makes of the two sides a shield—whose real strength lies in that interlocking area between them.

Borne by humanity in its age-long struggle with disease and death, the shield turns one side, public health, outward to the world—out to the shield-bearer's dangerous surroundings; the other side, medicine, turns inward—to the shield-bearer himself. The one has perhaps the broader outlook, the other undoubtedly the more intensive. But each after all functions successfully only because, when interlocked together, they fill the shield-bearer's great needs—as neither could alone.—British Columbia Board of Health.

SAN DIEGO ORGANIZES PUBLIC HEALTH ASSOCIATION

At a dinner meeting held October 4, 1934, the San Diego Public Health Association, composed of male members of the city and county health departments, was organized. Regular meetings will be held the first Monday of each month. The association is for the purpose of advancement of public health activities in San Diego City and County, the study of all matters pertaining to public health and sanitation, the introduction and study of new methods in public health administration, and for advancing closer cooperation of all agencies engaged in public health activities.

The following officers were elected for the ensuing year:

President—Dr. Alex M. Lesem, City-County Director of Public Health.

Vice President—Mr. G. C. Zuckweiler, Chief Sanitarian, County Health Department.

Secretary—Mr. G. H. Sieverling, Assistant Director of Public Health, City Health Department.

Treasurer—Dr. F. J. Bolender, County Veterinarian, County Health Department.

The layman can gain a fair idea of the manner in which tuberculosis affects the tissues by noting the mould seen in bread and cheese.—F. M. Pottenger.

PLAGUE THROUGHOUT THE WORLD

The Epidemiological Report of the Health Section of the Secretariat of the League of Nations states that during the year 1933 and the first six months of 1934 the world situation as regards plague has not changed to any very noticeable extent with the exception of the marked increase in the incidence of the disease in India, its most important focus. The disease is also markedly prevalent in Java and Madura and a considerable number of cases occur in Madagascar. The following table indicates the enormity of the plague situation in British India:

	Deaths from plague
1931	45,629
1932	62,958
1933	55,320
1934 (first 6 mos.)	53,940

In Java and Madura deaths have occurred recently as follows:

	Deaths from plague
1931	4,551
1932	6,442
1933	16,881
1934 (first 6 mos.)	11,355

In Madagascar there were 1672 deaths from plague during the first six months of 1934 and during the year 1933 there were 3715 such deaths. In central and eastern Africa a sharp decline of plague incidence occurred in 1933 and 1934. The bubonic and septicaemic form of the disease predominate in Madagascar. Plague here is limited to the high central plateaus at an altitude of over 4000 feet.

In British India the "plague year" ended in June, 1934, was the worst in recent years. The outstanding facts of the year included further spread of the disease on the high plateaus in districts already infected and a return of the disease in epidemic form in northern India, where the disease had been continually on the decline since 1929. Out of the total of 142,449 cases reported in 1933–34, 18 per cent were reported during July and September. The figures for India reported by the League of Nations are provisional and it is stated that they will have to be increased considerably before they can be considered as complete. Java suffered more from plague in 1933 and 1934 than in any other year since the introduction of the disease into the island in 1911. Few cases have occurred in European countries during the past year.

Since plague is widely prevalent in India and in Java, it is important that control measures against this disease be maintained continuously on the Pacific coast. That the disease is endemic in California is indisputable. It is only through the exercise of preventive measures that safety and security against this disease can be assured. The large number of deaths that have occurred in India during the first six months of this year emphasizes the importance of keeping plague out of this country and exercising effective control measures against the endemic form of the disease as it already exists.

MORE ABOUT COMMON COLDS

By Dr. Wilson G. Smillie, Professor of Public Health Administration, Harvard University School of Public Health

What is a cold?

The professors will tell you that "a cold is an acute, self-limited infection of the upper respiratory tract." This defines a cold exactly, but does not tell us what we want to know about it. Where do colds come from? Why do they occur? How can they be avoided?

Scientists have been making investigations for years to determine the cause of colds, but with no success. Recently, however, very important results were obtained. Since chimpanzees have colds, just like men, these animals were used for the study of this group of diseases, and, in this way, the cause of colds was finally discovered.

CAUSE IS A "VIRUS"

We now know that colds are caused by a "filterable virus"—a germ so small that it can not be seen even through the highest power microscope. These germs are found in enormous numbers in the nose and throat of a person who has a cold. The "virus" may be separated from all other germs and stored in a test tube in the laboratory, alive and unchanged for at least three years. At the end of this time one drop of this material is enough to give a chimpanzee a perfectly typical cold.

Human volunteers have been infected time and again with this virus from the test tube and have developed colds in 36 to 48 hours. Thus there seems to be no question but that the cause of colds has finally been determined. With this information in hand it is possible to make rapid strides toward the development of methods for prevention and treatment of colds. We know already that the cold virus is found in abundance in the nose and throat of a person during the early stages of a cold, but disappears after the first three to four days. Thus a person is most likely to give a cold to others when he is just coming down with it but is not a menace after four or five days.

MORBIDITY

Complete Reports for Following Diseases for Week Ending December 1, 1934

Chickenpox

238 cases: Hayward 1, Oakland 31, Richmond 1, Los Angeles County 21, Alhambra 1, Glendora 1, Long Beach 3, Los Angeles 39, Pasadena 1, Pomona 3, Santa Monica 3, Torrance 1, Lynwood 1, South Gate 1, Madera County 1, Madera 4, Marin County 1, Corte Madera 1, Larkspur 1, Ross 3, San Rafael 1, Fairfax 3, Merced County 9, Orange County 1, Riverside County 4, Beaumont 2, Riverside 3, Sacramento 8, Chula Vista 3, San Diego 6, San Francisco 27, San Joaquin County 9, Manteca 5, Burlingame 1, Santa Maria 2, Santa Clara County 2, Palo Alto 3, Vallejo 1, Stanislaus County 1, Trinity County 13, Visalia 2, Ventura County 12, Davis 1.

Diphtheria

48 cases: Oakland 1, Kern County 1, Bakersfield 1, Los Angeles County 2, Long Beach 2, Los Angeles 14, Redondo 2, Marin County 1, Orange County 1, Anaheim 5, Brea 1, Fullerton 1, Santa Ana 3, Riverside County 2, North Sacramento 1, San Diego 3, San Francisco 2, Santa Clara County 1, Tulare County 1, Tulare 1, Ventura County 1, Ventura 1.

German Measles

13 cases: Oakland 1, Burbank 1, Huntington Park 1, Los Angeles 2, Pomona 1, Anaheim 2, Santa Ana 1, San Joaquin County 1, Santa Clara County 2, Willow Glen 1.

Influenza

29 cases: Fresno County 1, Los Angeles County 6, Los Angeles 17, Roseville 1, San Diego 1, San Francisco 1, Stanislaus County 2.

Malaria

5 cases: Lodi 1, Sacramento County 1, California 3.*

Measles

127 cases: Oakland 2, Gridley 1, Calaveras County 1, Placerville 3, Fortuna 3, Los Angeles County 3, Burbank 1, Glendale 1, Los Angeles 1, South Gate 1, Orange County 2, Anaheim 1, Riverside 1, San Francisco 4, San Joaquin County 60, Stockton 8, Tracy 13, Santa Maria 14, Palo Alto 1, San Jose 1, Santa Cruz 1, Stanislaus County 1, Exeter 3.

Mumps

70 cases: Alameda County 4, Berkeley 4, Emeryville 3, Hayward 1, Oakland 5, Los Angeles County 1, Los Angeles 3, Monrovia 1, Maywood 1, Marin County 1, Larkspur 1, Nevada City 1, Placentia 2, San Francisco 7, San Joaquin County 4, Lodi 1, Stockton 1, Tracy 1, San Luis Obispo County 1, Santa Barbara County 7, Santa Maria 12, Santa Clara County 3, Willow Glen 1, Modesto 3, Woodland 1.

Pneumonia (Lobar)

34 cases: Berkeley 2, Alhambra 1, Los Angeles 15, Manhattan 1, Santa Monica 1, Orange County 1, Riverside County 1, Riverside 1, Sacramento 1, San Diego 2, San Francisco 2, Burlingame 1, Lompoc 2, Santa Barbara 1, Siskiyou County 1, Tulare County 1.

Scarlet Fever

191 cases: Albany 1, Berkeley 1, Oakland 9, Colusa County 1, Fresno County 5, Sanger 1, Brawley 2, Kern County 4, Los Angeles County 16, Alhambra 1, Azusa 1, Culver City 2, Glendale 1, Inglewood 1, La Verne 1, Long Beach 3, Los Angeles 39, Monrovia 1, Pomona 3, Redondo 3, San Gabriel 1, San Marino 1, Santa Monica 2, Whittier 1, South Gate 4, Bell 1, Gardena 1, Marin County 2, Monterey County 1, Orange County 2, Anaheim 1, Orange 2, Santa Ana 5, Laguna Beach 2, Roseville 5, Riverside County 1, Riverside 1, Sacramento County 2, Sacramento 4, Ontario 1, Chula Vista 2, San Diego 3, San Francisco 20, San Joaquin County 3, Lodi 1, Stockton 1, Santa Barbara 1, Santa Clara County 2, San Jose 6, Willow Glen 2, Vallejo 5, Stanislaus County 3, Tulare County 1, Visalia 1, Ventura County 2, Fillmore 1, Yuba County 1.

Smallpox

5 cases: Los Angeles 3, Watsonville 2.

Typhoid Fever

10 cases: Fresno County 1, Imperial County 1, Los Angeles County 1, Merced County 2, Sacramento County 1, Tracy 1, Tulare County 1, California 2.*

Whooping Cough

48 cases: Berkeley 4, Oakland 3, Alhambra 1, Culver City 1, Glendale 2, Huntington Park 2, Los Angeles 3, San Gabriel 2, South Gate 1, Orange County 8, Huntington Beach 1, Santa Ana 1, San Diego 2, San Francisco 10, San Joaquin County 1, Lompoc 3, Santa Barbara 2, Palo Alto 1.

Meningitis (Epidemic)

1 case: Los Angeles.

Dysentery (Amoebic)

1 case: Fresno County.

Dysentery (Bacillary)

3 cases: Los Angeles County 1, Los Angeles 1, Sacramento 1.

Ophthalmia Neonatorum

1 case: San Fernando.

Pellagra

3 cases: Los Angeles 2, San Francisco 1.

Poliomyelitis

25 cases: Kern County 4, Bakersfield 7, Los Angeles County 1, Huntington Park 1, Los Angeles 5, Riverside County 1, Sacramento County 1, North Sacramento 1, San Mateo 1, San Jose 1, Tulare County 1, Lindsay 1.

Tetanus

2 cases: Los Angeles.

Trachoma

2 cases: Santa Barbara County.

Encephalitis (Epidemic)

1 case: San Francisco.

Paratyphoid Fever

1 case: Placerville.

Jaundice (Epidemic)

1 case: Los Angeles County.

Food Poisoning

10 cases: Los Angeles 1, San Francisco 9.

Undulant Fever

2 cases: Los Angeles.

Coccidioidal Granuloma

1 case: Los Angeles.

Septic Sore Throat (Epidemic)

1 case: Kern County.

Relapsing Fever

1 case: Eldorado County

Rabies (Animal)

11 cases: Los Angeles County 3, Inglewood 1, Los Angeles 2, San Marino 1, Monterey 1, San Joaquin County 1, Stockton 2.

I am so sorry you are feeling less well. How is the phlebitis? No one ought to suffer from anything with such a pretty name. Did you ever stop to think that the names of diseases and the names of flowers are very similar? For instance, I might say, "Do come and see my garden. It is at its best now, and the double pneumonias are really wonderful. I suppose the mild winter had something to do with that. I'm very proud of my trailing phlebitis, too, and the laryngitises and deep purple quinsies that I put in last year are a joy to behold. The bed of asthmas and malarias is finer than ever this summer, and the dear little dropsies are all in bloom down by the lake and make such a pretty showing with the blue of the anthrax border behind them."—From the letter of one octogenarian to another, in "Madame Claire" by Susan Ertz.

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* Cases charged to "California" represent patients ill before entering the State or those who contracted their illness traveling about the State throughout the incubation period of the disease. These cases are not chargeable to any one locality.

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